Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
NUEVA VIDA BEHAVIORAL HEALTH

Respondent Name
HARTFORD UNDERWRITERS INSURANCE

MFDR Tracking Number
M4-14-3220-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
June 23, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Nueva Vida obtained preauthorization for 6 sessions of individual psychotherapy on 04/17/2013. Certification #04909 was issued for the 6 sessions with a date range of 04/17/2013 to 06/17/2013 with a date extension to 08/17/2013. The dates of service being denied for payment are 07/09/2013 and 07/24/2013. Prior authorization was obtained for all the services we provided, which were medically necessary in aiding the patient recovery for the work related compensable injury..."

Amount in Dispute: $ 382.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our investigation has found that: 2/21/12 – PLN 11 filed denying psychological conditions. 4/16/12 – IRO Case # 40177 – Upheld denial. The Hartford upholds denial of the disputed dates of service above."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 9, 2013 – December 9, 2013	90837 x 3 and 99361	$382.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.
   - W3 – Additional payment made on appeal/reconsideration.
   - 556 – This provider is not an authorized treater in workers; compensation.
   - 167 – This (These) diagnosis(es) is (are) not covered.
   - 269 – This billing is for a service unrelated to the work illness or injury.
   - 133 – The disposition of this claim/service is pending further review.
   - UNRL – Extent of injury not finally adjudicated. Reimbursement withheld – charge unrelated to compensable injury.

- 247 – A payment or denial has already been recommended for this service.
- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
- D1 – Duplicate.
- 15 – Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
- 293 – This procedure requires prior authorization and none was identified.
- 197 – Payment denied/reduced for absence of precertification/authorization.
- APPR – Reimbursement is being withheld as the treating doctor and/or services rendered were not approved based upon handler review. Please contact the claim handler for additional information.

Issues

1. Did the requestor resolve the dispute for work related illness or injury?
2. Do the services in dispute require prior authorization?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied date of service August 16, 2013 based on denial reason code "167 – This (These) diagnosis(es) is (are) not covered; 269 – This billing is for a service unrelated to the work illness or injury; 133 – The disposition of this claim/service is pending further review and UNRL – Extent of injury not finally adjudicated. Reimbursement withheld – charge unrelated to compensable injury." The date of service referenced above contains unresolved issues of extent-of-injury for the same service(s) for which there is a medical fee dispute. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) responses during the medical bill review process.

   Dispute resolution sequence: 28 Texas Administrative Code §133.305(b) requires that extent-of-injury disputes be resolved prior to the submission of a medical fee dispute for the same services. 28 Texas Administrative Code §133.307(c) (2) (K) provides that a request for a medical fee dispute must contain a copy of each EOB related to the dispute.

   Extent-of-injury dispute process: The Division hereby notifies the requestor that the appropriate process to resolve the issue(s) of extent of injury, including disputes or disagreements among the parties over whether the medical services in dispute were related to the compensable injury, may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1. As a result, date of service August 16, 2013 was not considered in this review.

2. Per 28 Texas Administrative Code §134.600(p)(7) states in pertinent part, "Non-emergency health care requiring preauthorization includes: (7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program;" Review of the submitted documentation finds two "Request for certifications" from The Hartford. The first dated April 17, 2013 has a start date of April 17, 2013 and end date of June 17, 2103. The approved service is for CPT code 90834-authorization number 1318740 for 6 visits. The second is a concurrent review determination extending the end date from June 17, 2103 to August 17, 2013.

   The carrier denied the submitted charge for July 9, 2013 and July 24, 2013 based on denial reason codes "15 – Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider; 293 – This procedure requires prior authorization and none was identified and 197 – Payment denied/reduced for absence of precertification/authorization." Review of the CMS-1500 documents that the requestor billed and disputes CPT Code 90837, not the preauthorized CPT code 90834. The Division finds that the disputed service was not preauthorized, as a result reimbursement cannot be recommended for CPT code 90837 rendered on July 9, 2013 and July 24, 2013.
3. 28 Texas Administrative Code §134.204 states in pertinent part, "(e) Case Management Responsibilities by the Treating Doctor is as follows: (4) Case management services require the treating doctor to submit documentation that identifies any HCP that contributes to the case management activity. Case management services shall be billed and reimbursed as follows: (A) CPT Code 99361... (ii) Reimbursement to the referral HCP shall be $28 when a HCP contributes to the case management activity."

   The requestor seeks reimbursement in the amount of $28.00 for CPT code 99361 rendered on December 9, 2013. Review of the submitted documentation titled "Case Management Note", does not meet the documentation requirements outlined in 28 Texas Administrative Code §134.204, as a result, reimbursement is not recommended for CPT code 99361.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		April 23, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.